

Reimbursement Services  
P.O. Box 534385  
St. Petersburg FL 33747-4385



Employee Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City, State Zip \_\_\_\_\_

Employee SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Company Name: Milwaukee County Client ID: 103039

FAX TO: 1-866-863-6598 (Reimbursement Account Administration)

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For faster service, fax this entire sheet, completed and signed, along with the appropriate documentation (receipts). Please complete all applicable spaces.

Mail your claim forms to: P.O. BOX 534385, St. Petersburg FL 33747-4385

To obtain a claim form, go to [www.benefitenroll.com](http://www.benefitenroll.com) (Your UserID is 1083clock#. Your password is the last four digits of your SSN.)

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable coverage period for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount requested for reimbursement and the total amount of receipts attached, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Flexible Spending Account

Service Date	Expense Type	Service Provider	Patient Name	Amount
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
Total Submitted				\$

Around the clock service at [www.benefitenroll.com](http://www.benefitenroll.com) Access your account data, obtain forms, and quickly find answers to your questions. Customer service professionals are available to assist you by calling 1-866-845-6271 from 7AM to 7PM CST Monday through Friday.